Client identified self according to Policy and Procedure 05-01-25: ☐Yes ☐ No ☐ N/A

*S=Meds targeted at core symptom. OS=Meds targeted at other symptoms. SE=Meds for side effects of S or OS.
SNP=Standardized Nursing Procedure.

Medication Name	Strength	Frequency	Quantity	Refill	Indication (check all that apply)*	Change from previous visit?	New/ Continuing/ Discontinue
					☐S ☐OS ☐SE	☐Yes ☐No	☐New ☐Cont. ☐D/C
					☐S ☐OS ☐SE	☐Yes ☐No	☐New ☐Cont. ☐D/C
					☐S ☐OS ☐SE	☐Yes ☐No	☐New ☐Cont. ☐D/C
					☐S ☐OS ☐SE	☐Yes ☐No	☐New ☐Cont. ☐D/C
					☐S ☐OS ☐SE	☐Yes ☐No	☐New ☐Cont. ☐D/C
					☐S ☐OS ☐SE	☐Yes ☐No	☐New ☐Cont. ☐D/C
					☐S ☐OS ☐SE	☐Yes ☐No	☐New ☐Cont. ☐D/C
					☐S ☐OS ☐SE	☐Yes ☐No	☐New ☐Cont. ☐D/C
					☐S ☐OS ☐SE	☐Yes ☐No	☐New ☐Cont. ☐D/C
					☐S ☐OS ☐SE	☐Yes ☐No	☐New ☐Cont. ☐D/C
					☐S ☐OS ☐SE	☐Yes ☐No	☐New ☐Cont. ☐D/C
					☐S ☐OS ☐SE	☐Yes ☐No	☐New ☐Cont. ☐D/C

Generic Equivalent permitted unless otherwise noted.

☐ County Pharmacy

Pharmacy Name:____Pharmacy Phone Number: (___)____________________

☐ Mail Out ☐ Fax Pickup: ☐ Pharmacy ☐ Clinic **Medi-Cal:** ☐Yes ☐No

Date ____________ Signature MD/DO or RN under SNP ____________ CA License No. ____________ CPT/HCPCS Code ____________

Printed Name ____________ DEA Numbe ____________

County of San Diego
Health and Human Services Agency
Mental Health Services

MEDICATION PRESCRIPTION

Client

Client:________________________________

MR/Client ID #: ____________________ **DOB:** __________

Address:________________________________

Program

Program: ____________________ **Phone #**______________

Address:________________________________